TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3091-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The '97799-Functional Restoration Program Daily Progress Note' was submitted with each claim. This note indicated the topic that was discussed each hour and a brief explanation of the topic was included. The number of units/hours billed on this particular note is located and circled at the top right hand corner. There are 4 group topics on each Daily Progress Note…The 5th unit/hour is sometimes billed for a Case Management/Individual Therapy/Return to Work Plan. In addition, the units for physical therapy are provided on the 'Snowden Orthopedic and Occupational Rehabilitation' note."

Amount in Dispute: $5,900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation was signed by unlicensed individual…The documentation did not include signature of supervising licensed provider(s) for the psychological components of the Chronic Pain Management Program billed. Texas Mutual relies on the above and all of the denial reasons noted on the EOBs and requests a resolution in its favor."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 13, 2016 January 14, 2016 January 15, 2016 January 18, 2016 January 19, 2016 January 20, 2016 January 21, 2016 January 22, 2016	CPT Code 97799-CP (59 hours) Chronic Pain Management Program	$5,900.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*, effective March 1, 2008, 33 TexReg 626, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
    - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
    - CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
    - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
    - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
    - 876-Required documentation missing or illegible. See rules 133.1; 133.210; 129.5; or 180.22.
    - 891-No additional payment after reconsideration.
    - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code and descriptions/instructions.

Issues

Does the documentation support billed service? Is the requestor entitled to additional reimbursement for chronic pain management program?

Findings

The requestor billed $5,900.00 for CPT code 97799-CP, a non-CARF accredited chronic pain management program, rendered on the disputed dates of service. The respondent denied reimbursement for CPT code 97799-CP based upon reason codes "CAC-16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication," "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information," and "892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code and descriptions/instructions."

28 Texas Administrative Code §134.204(h) states,

> The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

28 Texas Administrative Code §134.204(h)(1)(B) states,

> If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

28 Texas Administrative Code §134.204(h)(5) states,

> The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs:
>
> (A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill.

The Division finds that the requestor's documentation did not sufficiently support the 59 units of chronic pain management; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		03/09/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.